- Gunderson one.

- [Rebbe Ratner] Alright, starting. So first off, can you just say your name and what you do?

- I'm John Gunderson, I work at McLean Hospital where I oversee two clinical services dedicated to treating borderline patients and I do research here and teach.

- [Rebbe Ratner] Do you have a preference for what you'd like to do more?

- Well, that's hard, I'm not sure. I know that I like seeing patients and I miss that when I'm away from them.

- What do you like about seeing patients?

- Well, everybody's different. I always feel I'm learning. It's very creative and I can't help but get very involved, so time goes quickly.

- [Rebbe Ratner] Can you talk about how you got involved with treating borderline?

- Well, when I was a resident, I was curious, fascinated, and a little bit terrified by the phenomena of a group of patients which at that time weren't diagnosed, but who gave a great deal of difficulty to the nursing staff, to my fellow residents, our supervisors didn't know how to help us very much and we'd go home and talk about these patients and pretty soon our families knew about them and didn't want to hear anymore. And as a result of this, I did, even as a resident, a sort of preliminary effort to describe who they were and I got introduced to a not very well-known literature about a group of people called borderline, at that time borderline schizophrenic or borderline neurotic or atypical of a lot of things and not clearly having any center. When I went to the National Institute of Mental Health, I teamed up with someone who was a well-known psychologist who reviewed all the psychological testing literature on this group of patients and I compiled all the literature which was potentially relevant to them and we wrote a review which was called "Defining Borderline Patients" published in 1975 and not so long after that I came back to McLean, came to McLean where I was to study schizophrenia. But that article transformed my career. I was suddenly thought to be a great expert on a group of patients that actually kind of scared the bejesus out of me. But, so I got lots of referrals, lots of consultations, asked to give talks, had anxiety attacks because they didn't know what I was talking about. And then I got involved in doing research and did the work that defined the disorder and got it introduced into the classification system in 1980. So that's how I got into it. I got

very well known on account of an expertise I didn't have and I did the work I did was more based on an effort to get some control and distance from a phenomena that scared me.

- [Rebbe Ratner] Can you describe what you were seeing and what was scary about it for you?

- It was at once, well, I think probably at its heart I found the patient so appealing and I was frightened that I would be seduced and frightened of the prospect of myself rushing in as a rescuer and then getting hurt. So there was a push and pull to the patients which wasn't unique to me, which would preoccupy us all. That's...

- [Rebbe Ratner] Like when you say you were afraid about getting hurt, can you be more specific what you mean by that? What was in the transaction that could potentially be hurtful to you? 'Cause you're a clinician.

- Well, first of all, there was always the prospect that this very same person who on the surface seemed so appealing could turn suddenly into someone who would attack you for your incompetence and for being cruel. And that was something, especially when you're learning to become a professional caretaker and your identity is not that well settled that is scary. And I would

say that that remains an issue why a lot of professionals don't like working with borderline patients. They don't feel confident about withstanding that kind of attack on their skills. What was scary is that borderline patients can very suddenly and quite unexpectedly, 'cause you're there innocently trying to help, turn on you for your ignorance or even your cruelty. And this is something which, when you're insecure to begin with and you're starting your professional life, is frightening. And it remains an issue which many professionals recognize and is a source of their efforts to avoid working with patients with borderline personality disorder. Regrettably, because I think now when you're more settled professionally and know more about the disorder as we do now, that stigma is off-putting unnecessarily and that people who are well-trained don't offend borderline patients as much as we used to. And when we do offend, don't take it so personally. See it as something that is part and parcel of the work you're doing. And you can even learn to take professional pride in your ability to hear that without getting too disturbed. Listening respectfully, but taking from it what you can.

- [Rebbe Ratner] Okay. So specifically, so you were in a schizophrenic... I mean, the borderlines were often shoved in with schizophrenics, correct?

- Well, when I was a resident, it was a generic inpatient unit that had patients of all kinds. When I came to McLean in 1973, the unit

I was on was supposed to specialize in schizophrenia. But as it turned out, it soon became a place where lots of people sent people who didn't quite fit that diagnosis, but who might be identifiable as having this borderline condition. And hence, I was seeing a lot more patients than I had imagined or invited.

- [Rebbe Ratner] So two things. So what is... like, what is the borderline condition? And what was it then to you, and what is it now? How is that, has it changed? Or do you just have a-

- That's a difficult question to answer. The borderline condition, the way I describe it, is that it is a condition for people who grew up feeling that they did not get their needs met, and with the hope that if they could form the proper relationship, that that would solve their problems. And so when they enter their adolescent and young adult years, they try to get exclusive relations. In fact, many of them try to do that well before that, but it becomes more socially observable at that age. They try to form exclusive relationships with someone, and that invariably creates tensions which are unfeasible or... it's not workable. And the other person will feel like they're getting swallowed up. So they withdraw, and then the person with borderline personality disorder will get very anxious about this, and the anxiety takes the form of angry devaluation. "You never cared. All you said was a lie. I can't count on you. I should never have trusted you." What we call angry devaluation. And it alternates with, "There's something inherently wrong with

me. Now, as when I was a child, nobody can really love me and give me what I need, and there's something wrong and bad about myself." And it's under those circumstances that the person can become self-destructive, oftentimes cutting or burning or other forms of deliberate self-harm occur under those circumstances. They originally start out as a way of coping with this sense of badness, taking mental pain and converting it into something physical. But it gets converted with time into a cry for help. When it becomes something that's recognized by schoolteachers, friends, family, they oftentimes get a lot of solicitous attention. At that point, as soon as that happens, then they're back into the situation where somebody really cares and they're needy, idealizing, hopeful, and they can imagine that they're a good person and that they're lovable, and it starts all over again. They become very dependent on the attention from that other person. And then, when it's broken, the cycle starts again. That's my way of understanding this disorder.

- [Rebbe Ratner] So how, if that happens, because if someone's doing that, someone's doing those behaviors and they're getting positively reinforced for them because they're getting the things that it seems they most need, how do you start to show them that they don't need to do those things to get what they think-

- Well, life is a great teacher, and psychotherapy can accelerate the lessons that life would otherwise teach such people. The lessons are

that it never works, that they never can sustain the relationship which is based on this idea that somebody will never leave them or will never disagree with them or never disapprove of them. It just isn't gonna happen. So you've got a built-in obsolescence. Now, when you get a treater involved in this, the same thing can happen. There's high hopes that this is a person who's gonna really care, but the hour ends, they go home, they have their own life. It is inherent in the therapy relationship that there are limitations of availability and shared attention with other people. So that there is, just within the relationship to treatment, the hopes and then the recurrent intrusions of this ugly reality that an exclusive other is not going to come out of that situation that there's a learning. Some patients get reconciled to this and they create relationships which are not so exclusive or where their hopes are not so high. But part and parcel of that often is some kind of, there's a lack of reconciliation, there's a kind of depression that's associated with that they will never, ever get what they feel they really need and that they have to settle for many relationships that are more stabilizing. Each of them serves some of this function but none of them is really, really fulfilling. So it's the unusual borderline, but it can happen. The unusual patient with borderline personality disorder who can get into a relationship who is truly corrective of this basic handicap. It can sometimes occur through a stable partnership with another adult, a few times with therapists, but largely it's the therapy relationship is a springboard for doing better in the outside world and you might be able to get a partner in the outside world which really is fulfilling and after a period of

time your attachment becomes stabilized and more secure. Sometimes it happens when someone with borderline personality disorder has a child and the child provides a corrective relationship. It's a kind of non-contingent relationship where they really can feel fulfilled and it will, they interject or, there's a word I'm not, I'm blocking on, but they take into themselves a better sense of themselves as a good person and that then gets internalized, that's the word I was looking for, that makes them more secure in their other relationships. But those are the, it doesn't happen that often.

- [Rebbe Ratner] So what are the ingredients that allows that to potentially happen?

- Well, I think inherent what I've said is there's a lot of good luck. You find a partner who is really able to manage the vicissitudes which occur in the first couple of years of feeling rejected unnecessarily, perceiving anger when it isn't there, being very overreactive to, you know, criticisms and, but sustains it and over time the person learns to trust that person and in the process of that corrective relationship internalizes the idea that maybe I'm basically okay and maybe I'm not such a toxin and that's the way it would occur with a child also. Does that make sense?

- [Rebbe Ratner] Yeah, that makes sense. I mean, it's hard, but it makes sense. I mean, it's a lot of things have to line up for something like that to happen.

- Some of that is not so unlike it is for every one of us. You know, you have to be pretty lucky to get a good partner in life. Most of us enter into our partnerships at a time in our life when we're not that well suited for choosing sociological, biological factors push us towards this and then some of us are lucky and some aren't.

- [Rebbe Ratner] In terms of what you think it takes for someone to work with people who have personality disorders, is there a certain quality? I mean, is there a certain kind of therapist that can work with a population like this? Is there a certain-

- Well, it appeals to a lot of people who really see themselves as good caretakers and really want to get into these relationships because they see borderline patients as sort of helpless waifs and that gets a lot of people started. That's not necessarily something that works very well for them or for patients in the long run. Some of the people who get into it through that avenue get toughened up and learn that they have to hold people, the patients accountable and they have to be able to say things and do things that the patients aren't going to welcome and thank them for. So as a colleague of mine used to put it, is you have to combine kicks with

your kisses. So people can learn to do that but both are necessary. The best people from the beginning are people who go into this who have some ability to say no to people, have self-confidence, whose lives are fulfilled enough so that their self-esteem is not gonna rise and fall with the success of their patients. Those are the people who are best suited for doing well right from the start.

- [Rebbe Ratner] Can you talk a little bit about what, I mean, you essentially helped get the definition, get the diagnosis into the DSM.

- Yes.

- [Rebbe Ratner] What you did, how you sort of-

- Well, I started out earlier by saying that I reviewed the literature and from that summarized it into a set of characteristics which appear to define this otherwise heterogeneous and unlabeled group. Then developed an interview which was structured by which those characteristics could be assessed reliably. Then applied it to a group of patients, some of whom appear to have this syndrome and then others who had adjacent or bordering conditions. Schizophrenia at that time was considered to be a bordering condition and depression. And then identified the characteristics which best distinguished people with borderline

personality disorder as it came to be known from others. So, defined the syndrome, developed a reliable instrument for assessing it, identified the characteristics which best distinguish it, and a threshold which was optimal for differentiating it from others. At that time was something that had never been done for any personality disorder. And was the first time that this particular disorder had actually been assessed and there was any method for doing it, let alone just showing that it is distinct from others. We subsequently elaborated on that process by showing how borderline personality disorder was distinguished from other personality disorders and from bipolar disorder and from post-traumatic stress disorder and a whole series of other conditions with which it was sometimes overlapping or confused.

- [Rebbe Ratner] So, what were the characteristics and what were...

- Those are the characteristics that were entered into DSM-III and which were... have been only slightly modified in DSM-III-R, DSM-IV, and now in DSM-V when they were entertaining the idea of radical changes in the definition, they... the American Psychiatric Association decided to retain the same definition that's been there now for some 30 years. The definition involves what in psychiatric jargon is called three different phenotypes, three different sectors of psychopathology. The first, most discriminating and most discriminating involves the interpersonal relationships. Borderline patients have intense, unstable relationships marked by

shifts between idealizing someone and devaluing someone and marked by over, vacillation between over-involvement and dismissal or under-involvement. They also have fears of abandonment which are a more... and fears of rejection which is an associated feature which are the phenomena reflecting a real fear about being alone. So those two characteristics define the interpersonal relationships and some, including myself, feel that that is really where the core of this disorder is, is in the interpersonal area. A second major sector of psychopathology or phenotype has to do with affective lability or emotional dysregulation as it's become identifiable through dialectical behavior therapy. But this includes a tendency towards angry outbursts or inappropriate anger. Many patients will say that they're always angry or that they can't control their anger. Mood changes, mood changes that you could say are something that might characterize people with bipolar disorder but in borderline patients it characteristically involves feelings of anger and is characteristically very reactive to a social context. So it doesn't, it's not like the moods change because of some internal clock that is pushing the moods back and forth but it's very responsive to the social context and in particular to interpersonal, adverse interpersonal events. And a third part of that affective picture is emptiness. That's an interesting characteristic. Not all borderline patients will describe it. Those who do describe it, it seems enlisting to life histories as if it's something that developed as a result of a long-standing sense of being neglected so that there's an inner emptiness like a hungry child who has not been fed enough.

Another way to conceptualize it though is it's simply a feeling state. In any event, it's there, it's very characteristic, you don't see it in very many other patients and it can resolve but slowly and in theory if it resolves, I would like to think it's because for that subgroup that I talked about before who have attained some kind of stable partnership with another person. The third sector of psychopathology is belongs to the behavioral problem and here deliberate self-harm, recurrent suicidal ideation and/or acts is sort of the signal symptom of borderline personality disorder. Borderline patients often do hurt themselves and hurt themselves repeatedly. The more they do that, the more apt they are to be suicidal. These self-harm acts are both something that are self-punitive and a way of easing this dysphoric states of mind that they can't relieve otherwise. It also can become a call for help, a way of eliciting supportive responses from others. The other behavioral symptom has to do with patterns of impulsivity. Borderline patients typically are people who have unsafe sex, drive recklessly, in addition are frequently bulimic or substance abusing. So that's the behavioral realm. The last realm has to do with cognition and here borderline patients and this is why they were originally thought maybe to be an atypical form of schizophrenia can have these lapses of reality testing. They're interesting. For instance, they can be like paranoid ideas. The paranoid ideas usually occur when a borderline patient feels otherwise alone and the idea that somebody's watching them actually is a psychological way of not being alone. They'd rather have somebody watching them than being alone. They can also have sort of hallucinogenic type

phenomena when somebody's going at night. These are people who may have trouble going to sleep at night because they're alone and they may hear voices under those circumstances. They're not really psychotic but they're psychotic-like. I say they're not really psychotic because they reverse very quickly when you put the borderline person in a social context where there's other people around paying attention to them. Dissociation where people feel real or think other people are unreal. That's the other part of that final sphere. So that's the definition, more or less as it's been since 1978 and in the diagnostic system since 1980. One thing I haven't mentioned is a disturbed sense of self. A sense that they're not really stable. It changes. A lot of borderline patients will say that I behave a lot depending on who I'm talking to or who I'm with and what I perceive they want or what they expect from me. Ill-formed and unstable identity. There's an argument that could be built but that is a sort of blanket problem and everything else is subsumed within that and that's what one of the pioneers in this area, Otto Kernberg, would suggest and I think that's a viable way to look at it. How's this going, is it okay?

- [Rebbe Ratner] Good, yeah. How do you think it's going?

- Okay, I get tired of myself. It's good to have a break.

- [Rebbe Ratner] You want a break? All right, let's take three minutes. It's good.

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